

Medication Partnership Program

October 4, 2001

1c971 U.S. PRO

10/038458



Medicine Facts

Main Page

Message Box

New Patient

Edit/Delete

Delinquency List

General List

Logout

Edit / Delete**Query Box**Patient's Name Ex. [John]
[Smith]☒ All Patients

Name Query

Reset

Name

Edit / Delete

Enter the information.

Patient's Name Ex. [James]
[Bond]

Edit / Delete

Reset

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New Patient InformationFirst Name: Last Name: Medication: ☐Delinquency: ☒ days.Email Address: Telephone 1: Telephone 2: Member ID: Password: Re-enter Password: Additional

Information:

Continue >>

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Delinquency List

Name	Phone	email	Delinq
Ivanosky Ivan	516-456-1235	email@email.com	49
Jack Zimmer	385-8123 (office)	oop@email.com	10
Jeff Andrew	212-879-3905	jeffborensteinmd@cs.com	13
John Jones	234567	asdf	98
John Smith	718-779-8869	john@email.com	49
Koko Lee	123-123-4567	email@kokolee	49
Mary Smith	1234567	aaaa	98
Nanncy Kim	582-6523	email@email.com	10

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Dr. FREUD

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Questionnaire Data - Patient: George Philp

No	Question	10/12	10/4	10/3	9/29	9/22	9/20	8/16	8/15	8/13	8/9	8/3	7/30	7/23	7/14	6/
1	Sometimes I feel side effects, such as drowsiness or dizziness.	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2	Sometimes I feel side effects, such as drowsiness or dizziness.	no	yes	no	yes	no	yes	no	no	yes	yes	no	yes	no	no	yes
3	Sometimes I feel side effects, such as drowsiness or dizziness.	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
4	Sometimes I feel side effects, such as drowsiness or dizziness.	yes	no	yes	no	yes	yes	no	no	yes	yes	no	yes	no	no	yes
5	Sometimes I feel side effects, such as drowsiness or dizziness.	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	no

No	Question	10/12	10/4	10/3	9/29	9/22	9/20	8/16	8/15	8/13	8/9	8/3	7/30	7/23	7/14	6/
6	Question No4.(2)	always	always	always	never	never	never	never	never	never	never	never	never	never	never	no
7	Question No2.(2)	never	never	always	never	never	never	never	never	never	never	never	never	never	never	no
8	Question No1.(2)	sometimes	always	always	never	never	never	never	never	never	never	never	never	never	never	no
9	Question No3.(2)	never	sometimes	never	never	never	never	never	never	never	never	never	never	never	never	no
10	Question No4.(2)	always	never	sometimes	never	never	never	never	never	never	never	never	never	never	never	no

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Patients Questionnaire Information

Questionnaire Frequency: [1](#) 

- Questionnaire 1


Question

1: [Sometimes I feel side effects,such as drowsiness or dizziness.](#) 


Question

2: [Sometimes I feel side effects,such as drowsiness or dizziness.](#) 


Question

3: [Sometimes I feel side effects,such as drowsiness or dizziness.](#) 

Question

4: [Sometimes I feel side effects,such as drowsiness or dizziness.](#) 

Question

5: [Sometimes I feel side effects,such as drowsiness or dizziness.](#) 

- Questionnaire 2

Question 6:

[Question No1.\(2\)](#) 

Question 7:

[Question No1.\(2\)](#) 



Question 8:

Question 9:

Question 10:

Done

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